EXHIBIT D

INFERTILITY INSURANCE SETTLEMENT
C/O ATTICUS ADMINISTRATION
PO BOX 64053
SAINT PAUL MN 55164

<<claimantid>>_<classcode>><<seqid>>

Scan This Code to Complete Form Online:

Display Optional Forms Portal QR Code

<<LITIGATION MEMBER NUMBER>>

Claimant ID: <<claimant ID>>
<<FIRST NAME>> <<LAST NAME>>
<<ADDRESS>>
<<CITY>> <<STATE>> << ZIP>>

OUT-OF-POCKET EXPENSE SUBMISSION

Goidel et al., v. Aetna Life Insurance Company
U.S. District Court, Southern District of New York
Case No. 1:21-cv-07619 (VSB)

If (1) Aetna denied your request for precertification or your claim for one of an agreed-upon set of qualifying artificial insemination (intracervical insemination ("ICI") or intrauterine insemination ("IUI")) or in vitro fertilization ("IVF") procedures, or if Aetna would have denied your request for coverage for artificial insemination that you underwent, between September 1, 2017 and May 31, 2024, and you were in an Eligible LBGTQ+ Relationship as described in the Settlement Notice, (2) you have not requested exclusion from the settlement, and (3) you incurred out-of-pocket expenses arising from Defendant's denial or anticipated denial of your infertility coverage request that exceed your Default Dollars for Benefits amount or your Proof of Greater Covered Care award, you may be eligible for additional compensation and should complete this Out-of-Pocket Expense Submission.

Examples of potentially eligible out-of-pocket expenses include: cycles of IUI insemination; consultations with medical professionals regarding IUI services; vials of donor sperm; ultrasound and bloodwork monitoring in connection with IUI cycles; medication related to fertility treatment and trigger shots in connection with IUI cycles, if covered by your plan; ovulation predictor kits and pregnancy tests; and IVF insemination and related treatments, if covered by your plan, and for those aged 37 or younger, if you completed at least three IUI.

Fully completed and signed Out-of-Pocket Expense Submissions and accompanying support documentation must be received by the Settlement Administrator by Bar Date. Out-of-Pocket Expense Submissions will be evaluated by Special Master Hon. Steven Gold, who will determine what, if any, additional compensation you might receive from funds remaining in the Common Fund after all participating Class Members have been paid their approximately $10,000 payment or proportionately reduced payment if there are more than 200 Class Members.

FUNDS FOR OUT-OF-POCKET SUBMISSIONS MAY NOT BE AVAILABLE.
COMPLETING THIS FORM DOES NOT GUARANTEE ADDITIONAL COMPENSATION.

You may submit your completed form and documentation using any of the following options before **Bar Date**:

ONLINE: **www.InfertilityInsuranceSettlement.com**

MAIL: Infertility Insurance Settlement
c/o Atticus Administration
PO Box 64053
St. Paul MN 55164
EMAIL: **InfertilityInsuranceSettlement@atticusadmin.com**
FAX: 1-888-326-6411

Expense Amount and Date	Description of Expense and Support Documents *Identify the expense, what documentation you are providing in evidence of the expense, and how the expense is associated Aetna's denial or anticipated denial of your infertility benefits.*
$ Date:	
$ Date:	
$ Date:	
$ Date:	
$ Date:	
$ Date:	
$ Date:	

Add additional out-of-pocket expenses on a separate sheet of paper if necessary.

Any supporting documentation provided will not be returned. Please retain copies of your documents for your own records. You will be notified by mail and/or email if anything additional is needed for your Out-of-Pocket Expense Submission. Please make sure the Settlement Administrator has your current mail and email addresses.

I certify under penalty of perjury that this Out-of-Pocket Expense Submission and the documents provided to substantiate my expense submission are true and correct to the best of my knowledge.

_____ _____

Signature Date (mm/dd/yyyy)

Questions? Visit www.InfertilityInsuranceSettlement.com or Call 1-800-205-6861

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<<LITIGATION MEMBER NUMBER>>

Claimant ID: <<claimant ID>>
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<<ADDRESS>>
<<CITY>> <<STATE>> << ZIP>>

MISCELLANEOUS HARM SUBMISSION

Goidel et al. v. Aetna Life Insurance Company
U.S. District Court, Southern District of New York
Case No. 1:21-cv-07619 (VSB)

If (1) Aetna denied your request for precertification or your claim for artificial insemination (intracervical insemination ("ICI") or intrauterine insemination ("IUI")) or in vitro fertilization ("IVF") procedures, or if Aetna would have denied your request for coverage for artificial insemination that you underwent, between September 1, 2017 and May 31, 2024 and you were in an Eligible LGBTQ+ Relationship as described in the Settlement Notice, (2) you have not requested exclusion from the settlement, and (3) you experienced additional, miscellaneous harm arising from Defendant's actual or anticipated denial of your coverage request(s) that are not covered by any of the other benefits provided by this settlement (including the out-of-pocket expense submission), you may be eligible for additional compensation and should complete this Miscellaneous Harm Submission.

Examples of Miscellaneous Harm include, but are not limited to, extenuating circumstances rendering fertility procedures traumatic; extreme delay or total loss of the ability to parent due to Aetna's challenged policy; and medical complications or miscarriage associated with having to undergo fertility procedures you otherwise would not have undergone but for Aetna's challenged policy.

Fully completed and signed Miscellaneous Harm Submissions must be received by the Settlement Administrator by Bar Date and will be evaluated by Special Master Hon. Steven Gold, who will determine what, if any, additional compensation you might receive from funds remaining in the Common Fund after all Participating Class Members have been awarded their approximately $10,000 payment, or a proportionately reduced payment if there are more than 200 Class Members.

FUNDS FOR MISCELLANEOUS HARM SUBMISSIONS MAY NOT BE AVAILABLE
COMPLETING THIS FORM DOES NOT GUARANTEE ADDITIONAL COMPENSATION

You may use any of the following options to submit your form:

ONLINE: **www.InfertilityInsuranceSettlement.com**

MAIL: Infertility Insurance Settlement
c/o Atticus Administration
PO Box 64053
St. Paul MN 55164
EMAIL: **InfertilityInsuranceSettlement@atticusadmin.com**
FAX: 1-888-326-6411

Questions? Visit www.InfertilityInsuranceSettlement.com or Call 1-800-205-6861.

1. What harm did you experience as a result of Defendant's denial or anticipated denial of infertility coverage that is not addressed by any of the other benefits offered by this settlement?

2. Provide details on how or why you believe the item(s) described in your answer to question 1 are the result of Defendant's denial or anticipated denial of your request for infertility coverage.

3. Do you believe that the harm(s) you described is remedied? Why or why not?

4. Is there anything else you would like to share about what happened to you following the denial or anticipated denial of infertility coverage?

Add additional miscellaneous harm details on a separate sheet of paper if necessary.

You will be notified by mail and/or email if anything additional is needed for your Miscellaneous Harm Submission. Please make sure the Settlement Administrator has your current mail and email addresses.

I certify under penalty of perjury that this Miscellaneous Harm Submission and any applicable documentation provided to substantiate my miscellaneous harm are true and correct to the best of my knowledge.

_____ _____

Signature Date (mm/dd/yyyy)

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PROOF OF GREATER COVERED CARE SUBMISSION

Goidel et al. v. Aetna Life Insurance Company
U.S. District Court, Southern District of New York
Case No. 1:21-cv-07619 (VSB)

If Aetna has not already paid for artificial insemination procedures (intracervical insemination ("ICI") or intrauterine insemination ("IUI")) for which you submitted precertification requests or claims, or for which you submitted a Claim Form if you are a Category C Class Member, and those services would have been covered by your healthcare plan if not for the Definition of Infertility,[1] **YOU WILL AUTOMATICALLY RECEIVE $2,300**. If you incurred expenses in an amount greater than $2,300 for artificial insemination procedures that would have been covered by your healthcare plan but for Defendant's Definition of Infertility, you may be entitled to additional compensation and should complete this Proof of Greater Covered Care Submission.

Fully completed and signed Proof of Greater Covered Care Submissions must be received by the Settlement Administrator by Bar Date. Proof of Greater Covered Care Submissions will be evaluated by the Defendant, who will have sole discretion in determining what, if any, additional Dollars for Benefits Payment compensation you may be entitled to.

Documentation that you provide as supporting evidence will not be returned. Please retain copies of your documents for your own records. You will be notified by mail and/or email if anything additional is needed for your Proof of Greater Covered Care Submission. Please make sure the Settlement Administrator has your current mail and email addresses. Use any of the following options to submit your form and documentation before **Bar Date**:

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EMAIL: **InfertilityInsuranceSettlement@atticusadmin.com**
FAX: 1-888-326-6411

[1] For purposes of this settlement, the "Definition of Infertility" means Aetna's Clinical Policy Bulletin No. 327 in effect when the Amended Complaint was filed, which required individuals without a sperm-producing partner to undergo 6 or 12 cycles of artificial insemination, depending on the individual's age, in order to establish unexplained infertility and qualify for healthcare coverage of fertility services.

STEP 1: CLASS MEMBER INFORMATION

Class Member First Name | **Class Member Last Name** | **M.I.**

If the address on page one is correct check here: ☐ **If the address on page one is not correct, or if no address is present, provide info below:**

Aetna Member Number (W Number):

Class Member Address

City | **State** | **Zip Code**

Class Member Email Address: | **Class Member Telephone:** | **Pick One:** Mobile ☐ Home ☐ Home ☐

STEP 2: FERTILITY TREATMENT INFORMATION

Please provide information in the chart below for each cycle of artificial insemination you received between September 1, 2017, and May 31, 2024 that, in total, would have resulted in an aggregate reimbursement exceeding $2,300 by your Aetna healthcare plan. Supporting evidence for each procedure included is required and must be submitted with this form. Add additional procedures on a separate piece of paper if necessary.

Descriptions of the applicable artificial insemination Codes covered by this settlement are as follows:

(1) S4035-Artificial Insemination Menotropin
Stimulated intrauterine insemination

(2) 58321-Artificial Insemination; Intra-Cervical
In this procedure, the provider inserts prepared live sperm into the cervical canal.

(3) 58322-Artificial Insemination; Intra-Uterine
In this procedure, the provider inserts prepared live sperm into the uterus through the cervical canal.

Cycles of in-vitro insemination ("IVF") will not qualify you for Class Membership and should not be submitted.

FIRST CYCLE BETWEEN SEPTEMBER 1, 2017, AND MAY 31, 2024:

Date of Service (mm/yy/dddd): _____

CPT Code- Check the box(s) that apply (see page 2):

S4035 ☐
58321 ☐
58322 ☐

Provider TIN/PIN: _____ Provider NPI: _____

Provider Name: _____

Provider Address: _____

_____

_____

Provider Phone: _____ Amount Paid _____

SECOND CYCLE BETWEEN SEPTEMBER 1, 2017, AND MAY 31 1, 2024:

Date of Service (mm/yy/dddd): _____

CPT Code- Check the box(s) that apply (see page 2):

S4035 ☐
58321 ☐
58322 ☐

Provider TIN/PIN: _____ Provider NPI: _____

Provider Name: _____

Provider Address: _____

_____

_____

Provider Phone: _____ Amount Paid _____

THIRD CYCLE BETWEEN SEPTEMBER 1, 2017, AND MAY 31, 2024:

Date of Service (mm/yy/dddd): _____

CPT Code- Check the box(s) that apply (see page 2):

S4035	☐
58321	☐
58322	☐

Provider TIN/PIN: _____ Provider NPI: _____

Provider Name: _____

Provider Address: _____

_____

_____

Provider Phone: _____ Amount Paid _____

**Please visit www.InfertilityInsuranceSettlement.com for an Appendix for additional cycle history.*

STEP 4: DOCUMENTATION

Provide the required supporting evidence related to the artificial insemination procedure(s) described in **STEP 3**. Examples of acceptable forms for supporting evidence might include a bill from your provider (with proof of payment, i.e. cancelled check or credit card statement). Evidence provided must, at a minimum, confirm (1) you received a service, (2) what service you received, (3) that you were billed for a service, and (4) you paid for the service received.

STEP 5: CERTIFICATION AND SIGNATURE

I certify under penalty of perjury that the information included in this Proof of Greater Coverage Submission and the accompanying supporting evidence of the procedures completed are true and correct to the best of my knowledge.

_____ _____

Signature Date (mm/dd/yyyy)

Return to page 1 of this Proof of Greater Covered Care Form for details on how to submit your completed form and accompanying supporting evidence documentation.